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ABSTRACT

In light of reduced or eliminated federal funding, this report discusses mental health services provisions. The history of mental health service funding is presented. Funding responsibility is traced from communities, to states, to private health insurance, to federal assistance, to community provision with state and federal funds, and finally to reduced federal involvement forcing greater state funding. Current mental health financing structure is discussed in these categories: (1) categoric service provision including state appropriations and state contracts; (2) benefit programs including Medicaid, Medicare, federal block grants, and private sector funding; and (3) cash transfers including Supplemental Security Insurance and social services Title XX block grants. Seven general legislative guidelines for states are presented. Particular state laws pertaining to mental health services are given. Six states' programs are briefly summarized. In a discussion of future trends and implications, efficient use of public and private sector resources and cost containment are emphasized. A case study of Oregon is presented. Thirteen references are listed. (ABL)

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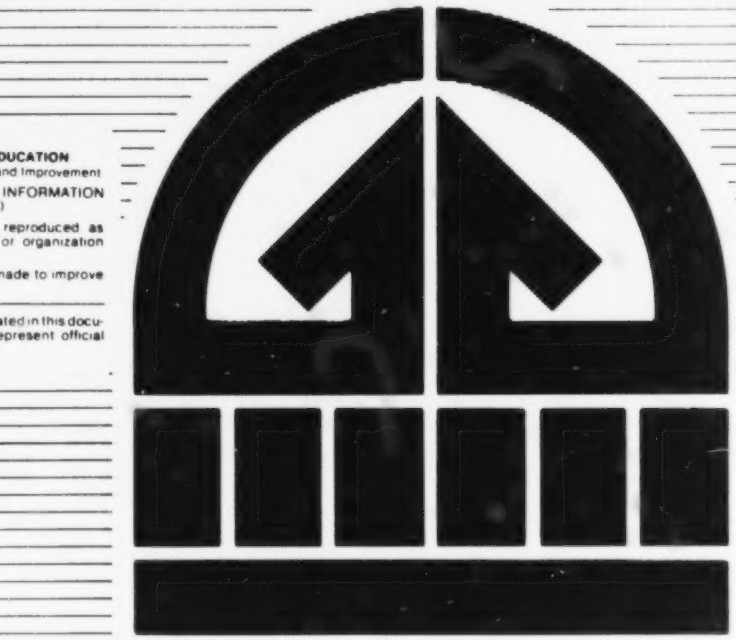

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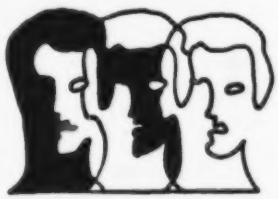

MENTAL HEALTH PROJECT

Human Resources Series

MAKING ENDS MEET:

MAXIMIZING THE MENTAL HEALTH DOLLAR

by

Rebecca T. Craig

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MAKING ENDS MEET:
MAXIMIZING THE MENTAL HEALTH DOLLAR

INTRODUCTION

The direct cost of mental health care in the United States was estimated to be between $17.2 and $19.9 billion during fiscal year 1981. Expenditures of state mental health agencies (SMHA) and selected federal and state agencies providing services to the mentally ill amounted to over $12 billion in 1983. Over half of this amount, $7.1 billion, is directly controlled and administered by SMHAs, with approximately $5 billion coming from state governments (1, p.1).

State legislatures have control over the amount and level of funding for mental health care within the states. With reduced or eliminated federal funding, legislators are becoming increasingly concerned about the provision of services to this needy population. States are struggling to address a variety of mental health funding issues, including: mandated mental health insurance coverage, disproportionate funding distribution between outpatient and inpatient services, trends toward the usage of prospective payment systems or other capitation measures and community care funding disincentives.

HISTORICAL PERSPECTIVE (2)

During colonial times, local communities were responsible for the care of the mentally ill. With the development of the state hospital, however, the financing and locus of care was shifted from the local community to the state. The mid 1800s saw the establishment of the state hospital system that was to be the dominant form of care for the next hundred years. By 1900, 100 state hospitals were in operation--this system of care was unequaled in size and expansion in any other area of medicine.

Health insurance for the general public came into existence during the Great Depression, ensuring that patients could afford to be treated and that hospitals would get paid. Although insurance plans were initially arranged around general hospitals where mentally ill were rarely treated, wage freezes during World War II stimulated a demand for fringe benefit improvements. Health insurance benefits were subsequently expanded, including improved benefits for psychiatric care. In an effort to limit risk, however, providers began to impose their own arbitrary limits on coverage.

The World War II era had a profound effect on the treatment of the mentally ill, the nation's attitude toward mental illness and the federal government's involvement in the provision of mental health services. This new awareness, in part, resulted in the passage of the National Mental Health Act of 1946. Although the federal government had previously funded only two types of state-run clinics, the act provided funds for training and research in mental illness. And perhaps most important, the federal government became involved in providing direct aid to states for the establishment of psychiatric clinics for the first time.

The Community Mental Health Centers Act of 1963 shifted a sizable portion of responsibility for the mentally ill from the state institutions to the community. A further shift in federal responsibility for the mentally ill occured with the development of Medicare, Medicaid and Title XVI Amendments to the Social Security

Act. Although limitations were immediately imposed on the mental health benefits of these programs, opportunities enabled states to shift much of the funding burden to the federal government. However, the Mental Health Systems Act of 1980, the creation of the block grant mechanism in the Omnibus Budget and Reconciliation Act of 1981 and the climate of the current administration have forced the states to assume again a greater role in the care and treatment of the mentally ill, while the federal government assumes a smaller share of fiscal responsibility.

With this shifting back and forth of responsibility for the mentally ill, the financing of mental health services has become a complicated mix of mechanisms and systems that varies from state to state. The lack of consistent and adequate financing for mental health care contributed to major gaps in the service system. Limited cooperation and coordination between the levels of government has resulted in the shifting and dumping of the mentally ill between system levels. Also, certain aspects of federal, state, local and private sector involvement have served as disincentives to effective community care and barred needy individuals from participation in programs.

FINANCING MENTAL HEALTH SERVICES

Public policy in the past has opted for categoric service interventions to finance mental health care through direct budget allotments for specified services or facilities--initially through the state hospital and then through the community mental health center and related provider programs. In recent years, most states have been moving toward benefit program interventions or mainstream financing mechanisms in an effort to shift as much of the funding burden as possible to major federal entitlement programs. Barbara Dickey, Harvard Medical School and Howard Goldman, University of Maryland Medical School, has categorized today's complicated mental health financing structure into the following methods: categoric service programs, benefit programs and cash transfers (3).

Categoric Service Programs

As with state hospitals and community mental health centers, funds for categoric service programs are provided by the government directly to the providers. Mix and quality of services offered to those who enter the system are determined by the providers, while the types of services and eligibility criteria are determined by regulation or negotiation between the funding source and the provider (4, p.s35).

State Appropriations. State public financing of mental health services is based on appropriations to the state mental health agencies (SMHAs) and other related state agencies. Appropriations to state agencies are determined through the same legislative process by which other segments of the government obtain funding. In many states, this funding allocation occurs in the context of policies and regulations designed to maximize control at the state level. Efficient fiscal management at the local level is made difficult by auditing and oversight concerns which frequently result in restrictions.

State Contracts. In an effort to avoid some of the restrictive regulations associated with direct allocation, many states attempt to purchase services through competitive contracting. With reduced or eliminated competition among vendors, however, there is evidence that the expected benefits are rarely achieved. Although these problems may occur at either state or local levels, local contracting may be able to increase accountability among vendors.

Funding mechanisms used by state authorities for dispersing funds to local providers include contracts for service, grants-in-aid, special grants and performance contracts. Many states have taken on more responsibility for determining services and funding as a result of legislation. State mechanisms allocating resources for community mental health services can generally be divided into four categories (5, p.4):

- Funds allocated directly by the legislature with no formal criteria used (one state);
- Minimum criteria set by administrative rules and grant applications (six states);
- Allocation of funds by state mental health agencies based on service and program goals (14 states);
- Formula used to determine fund allocation among counties, regions or individual programs (17 states).

Benefit Programs

In a benefit program, a specific set of services is provided through a voucher system or social insurance program. The consumer is restricted to a prescribed set of services and providers, such as Medicaid, Medicare and prepaid health insurance programs (4, p.s35).

Medicaid. Medicaid is a state-run medical assistance program operated under federal guidelines that require the provision of basic health and rehabilitation services to those whose income falls below certain levels and are eligible to receive payments through one of the federal welfare programs. Medicaid has become a major source of funds for many state mental health systems, despite its restricted use for those people between 21 and 65 years who are in institutions for mental disease.

With the implementation of the Medicaid program, the federal government began assuming greater responsibility for the provision of long-term mental health care and states were able to capture federal revenues from Medicaid by shifting costs from state hospitals to nursing homes. As Medicaid costs have risen, along with the state's portion of the program, federal and state policy-makers have attempted to contain rising nursing home expenditures. Although home and community-based waivers were developed to shift care from nursing homes, few waivers were provided for mental health services and the program is not currently issuing the waivers. The development of prospective payment systems has further limited mental health care reimbursement as most psychiatric hospitals were exempted from the established rates.

Medicare. Medicare, while providing broad coverage for a variety of health services and products, is limited with respect to psychiatric care. Hospital Insurance provides for limited inpatient care in freestanding psychiatric hospitals and Supplemental Medical Insurance provides only a $250 reimbursement for $500 of outpatient medical care. For the long-term mentally ill qualified for the program, the benefit limits and cost-sharing requirements make mental health care either inadequate or extremely expensive.

Federal Block Grants. Categorical grants and block grants to states provide other major federal funding sources for mental health care. Funding for the Alcohol, Drug Abuse and Mental Health (ADMH) block grant, which consolidated a number of federal assistance programs, is of special concern in financing mental health services. Operational funding of community mental health centers for specific services and coordination of mental health and health care is provided by the mental health portion of the grant. States must comply with a number of detailed requirements and funds are allocated under a formula related to past spending.

Private Sector Funding. Although public dollars have dominated service funding for the mentally ill for over a hundred years, there has been a rapid growth in private third-party payments for some mental health services over the past three decades. As of 1985, 12 states require minimum benefits, 12 states require availability of benefits and 2 states require coverage for certain services and the availability of coverage for others (6). Mental health coverage is still more restrictive in number of days and visits covered, dollar coverage and co-insurance rates than general health coverage.

Significant changes are now occurring in private sector reimbursement systems that will affect future mental health financing in such areas as cost control, increased competition, alternative payment mechanisms, corporate prevention efforts and a redesigning of benefit packages. However, private health insurance probably will not be a financial solution in caring for the long-term mentally ill.

Cash Transfers

The cash transfer mechanism allows the government to transfer cash directly to the individual. Eligibility requirements and amount of funds to be provided to the individual are determined by the government. Cash transfers, such as SSI, welfare, and food stamps, are helpful in assisting individuals to obtain nonmedical supports (4, p.s35).

Supplemental Security Disability Insurance and Supplemental Security Insurance. Social Security Insurance Disability Insurance (SSDI) replaces wages lost due to severe and extended disability. Supplemental Security Income (SSI) provides assistance at subsistence levels to needy, aged, blind and disabled persons who meet uniform, nationwide income and asset elgibility criteria. SSDI is funded totally by the federal government from payroll deductions and is related to the disabled worker's employment history, with an average monthly payment of $450 (4, p.s37). SSI payments are obtained from general revenues, with an average benefit award of approximately $300 per month; states can elect to supplement this payment (4, p.s37). SSI entitles the recipient to Medicaid, while SSDI provides access to Medicare.

These monthly payments are crucial in defraying living expenses of residential facilities not covered under Medicaid. However, SSI and SSDI regulations pose particular and critical problems for the long-term mentally ill. These difficulties include a complicated application process, penalities lowered against the working disabled and income forfeiture when a disabled person receives benefits from a household provider.

In recent years, the Social Security Administration has attempted to become more responsive to the current treatment practices and needs of the mentally ill. Reforms have been implemented which reduce barriers previously inherent in the system. For example, the disability determination process has been revised to measure more appropriate criteria and the benefits of disabled workers can be continued for specified periods if they become employed.

Social Services. Social Services (Title XX) block grants constitute the largest block grant to the states and are primarily used to prevent institutionalization through the provision of a range of community-based services. The portion of funds allocated for mentally ill persons varies from state to state and is often difficult to determine due to reporting criteria. However, those constituencies with higher political visibility are more likely to receive funded services than the mentally ill. In addition, increased program costs and decreasing public funding have encouraged states to charge for services and to target services for the most underserved.

GENERAL LEGISLATIVE GUIDELINES

State legislators should consider establishing a framework for a financially sound and responsive mental health system. The following broad concepts can provide legislators with general directions for policies affecting the funding of mental health services.

To promote the most effective utilization of resources and access to existing resources, states need to develop fiscal/management models that make the best use of scarce resources, prioritize the most-in-need populations, coordinate the various funding mechanisms and close service system gaps.

States need to oversee the coordination of services and provide the legal framework for service delivery. This coordination and cooperation can be achieved by bringing public and private resources together, providing fiscal incentives for treatment of underserved populations and community care, and providing care to the most diffficult and disabled groups.

State legislatures and mental health agencies need to look at all costs involved in providing care for the mentally ill. Reducing costs in one program may increase costs in another through the transfer of clients from one service arena or delivery system to another.

A better system of contract management, budgeting and management of information is needed in state mental health agencies to coordinate the increasingly complex and decentralized system of mental health care.

Financing of psychiatric and human services should encourage states and localities to meet the needs of the mentally ill instead of allowing reimbursement to drive the system. Federal, state and private programs should remove specific eligibility requirements and service restrictions which pose obstacles to the mentally ill and serve as disincentives to effective community care.

Private insurance programs must be encouraged to provide financial incentives for the provision of care in the least restrictive, least costly environments. Benefit levels for treatment of mental illness should also be on a par with the treatment of physical illnesses.

States should encourage creative and efficient models for improving mental health financing. For example, states could purchase services from public and private vendors instead of providing services directly. Creative models must be developed to encourage mental health providers to use entrepreneurial means of raising money for those services which are not reimbursed under existing programs. States should explore ways to convert closed or partially closed state hospital facilities and channel accrued revenues directly back into the mental health system.

THE STATES' RESPONSE IN RECENT YEARS

Legislation

With declining federal dollars, states are again assuming the major responsibility for the financing and care of the mentally ill. Over the past few years, there has been a flurry of activity within the state legislatures related to the financing of mental health care.

Residential Treatment Programs. Arizona (1984 Ariz. Sess. Laws, Chap. 389), California (1984 Cal. Stats., Chap. 1691), Louisiana (1981 La. Sess. Laws, Act 770), New York (1983 N.Y. Laws, Chap. 61 and 1984 N.Y. Laws, Chap. 298) and Texas (S.C.R. 62 and 63, 1985) addressed the problem of funding residential treatment programs for the mentally ill. Arizona provided that the state may require no more than a 25 percent match of local or other funds in the establishment of residential treatment programs. Louisiana established a Community Residential Program Development Fund to provide loans to cover the initial expenditures related to starting community residential programs. Texas mandated the development of a plan for the reimbursement of rehabilitative residential programs in lieu of more costly programs. During its 1986 session, Pennsylvania (H.B. 993) may soon require the state to pay the entire cost for community residential programs for all mentally ill who have been removed from their homes and are not in state-operated facilities.

Construction, Renovation or Expansion of Facilities. At least two states, have addressed the issue of financing the construction, renovation, or expansion of mental health facilities. Colorado (1983 Colo. Sess. Laws, Chap. 339) authorizes county commissioners and city councils to levy a tax for mental health services. Texas (1985 Tex. Gen. Laws, Chap. 500) allows the use of funds to renovate existing community center facilities, as well as to construct new facilities, through liens on the center's property. During the 1986 session, California (S.B. 182 and A.B. 1963), Maryland (1986 Md. Sess. Laws, Chap. 315) and New York (A.B. 8516/S.B.7094) are also considering legislation which would affect the renovation or construction of mental health facilities.

Community Mental Health Services. At least five states, California (1985 Cal. Stats., Chap. 1081), Illinois (1985, Ill. Laws, P.A. 84-261), New Jersey (1984 N.J. Laws, Chap. 435), New York (1983 N.Y. Laws, Chap. 816 and 1974 N.Y. Laws, Chaps. 620, 621) and Wisconsin (1973 Wis. Stats., § 51.42) addressed the general issue of financing community mental health services. California provided an equitable means of allocating state mental health funds based upon relative need. Illinois created the Mental Health Education Fund and authorized contributions from tax refunds. New York provided local governments with 100 percent reimbursement for various services provided to the deinstitutionalized mentally ill living in the community. The Wisconsin Legislature appropriated money for mental health services and allocations are made to each county on the basis of a formula.

During the 1986 session, Alaska (1986 Alaska Sess. Laws, Chap. 132), California (A.B. 3205), Colorado (1986 Colo. Sess. Laws, Chap. 210), Ohio (H.B.137), New York (A.B. 2765, A.B. 3697, A.B. 3698 and A.B. 8516), Tennessee (Tenn. SJR 348, 1986) and Wyoming (1986 Wyo. Sess. Laws, Chap. 30) are considering legislation during the 1986 session which would affect the funding of community mental health services. Wyoming is now able to authorize Medicaid reimbursement for services provided by certified mental health centers and clinics. Alaska's legislation has established a commission to develop a mechanism for dedicating state land revenues to mental health programs.

At least three states, Florida (1985 Fla. Laws, Chap. 85-253), Illinois (1985 Ill. Laws, P.A. 84-309) and Louisiana (1983 La. Sess. Laws, Act 672) passed legislation encouraging family involvement in the financial support of the mentally ill. Florida established a trust company and umbrella trust fund for the benefit and support of developmentally disabled and mentally ill individuals. Illinois established a family support demonstration program to encourage families to care for their mentally ill member in the home. Ohio (H.B. 99) is considering legislation during the 1986 session which would provide tax exemptions for those caring for the mentally ill.

Special Populations. A variety of states have examined the issue of funding services for special groups within the mentally ill population. Arizona (1983 Ariz. Sess. Laws, Chap. 252), California (1984 Cal. Stats., Chap. 1327), Connecticut (1985 Conn. Gen. Laws, P.A. 85473), Maine (1979 Me. Laws, Chap. 10), New York (1984 N.Y. Laws, Chap 305), Oregon (1985 Or. Laws, Chap. 567 and 1981 Or. Laws, Chap. 750) and Wyoming (Wyo. Stats. § 21.13.315) have addressed the issue of funding services for mentally ill children and youth. Arizona (1986 Ariz. Sess. Laws, Chap. 398) established the mechanism needed to develop a capitation system of funding services for the chronically mentally ill. Illinois (1985 Ill. Laws, P.A. 84-383) has authorized incentives for nursing homes to develop special programs for Alzheimer's victims. New York (1983 N.Y. Laws, Chap. 61) has created the Homeless Housing and Assistance Program, establishing funds for housing assistance to the homeless and for emergency shelters.

Programs

During the recent years of budgetary constraints, states have taken diverse approaches to financing services for the mentally ill. The four approaches states have taken to finance community services which will be explored in the following section include: innovative uses of Medicaid, private/public partnerships, interagency agreements and shifting institutional resources to community settings. Summaries for the following state approaches were largely excerpted from Financing Community Services for Chronically Mentally Ill Individuals, Report on Approaches to Problems, Policy Resources, Inc., 1986 (7).

Delaware. A new initiative has been implemented by the Department of Health and Social Services, Division of Mental Health, to develop group homes for the mentally ill by working with private investors. Under this plan, private investors purchase the housing units and a guaranteed rent is paid by the department for the leases. Another project within the department strives to enhance access to community housing by the mentally ill. A mental health response team provides all needed services to mentally ill tenants in housing authority units in exchange for the Housing Authority expediting their client's applications.

Louisiana. In an attempt to transfer chronic institutionalized patients into the community, Louisiana developed a mechanism which allowed funding to follow the patients by partitioning the hospital into a hospital and community service cost center. Selected patients were relocated into an inpatient unit where they received the needed structure and training required in community living. Following the discharge of each patient into the community, wards were closed one at a time and staff were moved into vacancies in other programs. Funds previously used to support inpatient services were transferred to the community programs and one-third of the hospital costs were realized as state budget savings.

Maryland. In 1980, three state agencies signed an interagency agreement that laid out plans for a coordinated system of care for the mentally ill. The project

charged with implementing this service system was responsible for providing the mentally ill with access to a range of community services, including room, board and personal care. Each eligible client in the project receives a Supplemental Security Income (SSI) and a Public Assistance to Adults (PAA) check which are turned over to the housing provider, except for a personal needs allowance. Subsequently, each client is able to pay for room, board and personal care services directly and receives free health care with the issuance of a Medical Assistance card.

Massachusetts. In 1986, Governor Michael Dukakis of Massachusetts proposed efforts to improve services for the chronically mentally ill through a variety of measures which use creative approaches to funding community housing. The proposed ventures include the following:

- Selling or leasing potentially surplus state hospital land, with a condition that 10-15 percent of the units would be developed for Department of Mental Health clients;
- Using capital funds for the development of housing for the disabled by local housing authorities;
- Expanding existing programs that provide rent subsidies to private landlords to guarantee rental income to owners and rental assistance to low-income clients; and
- Setting aside a certain percentage of units in privately developed and publicly financed rental housing.

New York. Established five years ago, the state-funded Monroe-Livingston Demonstration Project has teamed community mental health providers with state and local funding organizations to create a comprehensive coordinated community planning agency. Integrated Mental Health Services, Inc. encourages outpatient care through the following financial incentives (3, pp.26-27):

- Contract Revenue System--Community mental health agencies are provided stable and predictable funds through a delivery and finance system.
- Capitation Payment System--To ensure adequate care, a delivery and finance system allows funding to follow chronically mentally ill patients from the hospital into the community.
- Start-Up Services for CPS--Certain community programs are expanded or developed before patients are enrolled.
- Management Information System--A data system enables participating agencies and Integrated Mental Health Services, Inc. to monitor patient outcomes and support the financial and management reporting systems.

Washington. In an attempt to reduce hospitalization and improve client functioning, the Washington State Mental Health Division developed and implemented a new set of community mental health Medicaid policies in 1984. Those activities and services for which it was difficult to measure direct benefits to the mentally ill were eliminated. Case management services, client collateral services and a new, three-tiered set of day treatment services were included in the Medicaid community contract. Although the changes are expensive, the cost of providing mental health services in the public sector will be lessened in the medium-to-long run.

FUTURE TRENDS AND IMPLICATIONS

With the Gramm-Rudman-Hollings initiative and current Reagan administration policies, states can expect fewer federal dollars for the financing of mental health services. States will be assuming more responsibility for the care of the mentally ill and must be able to meet the increased expectations and demands for service with the finite resources available. This seemingly insurmountable task could be accomplished through the effective and efficient use of resources, cooperative efforts between public and private sectors and the various governmental levels, innovative methods of financing and coordination and continued transferral of resources from inpatient settings to community programs.

In the future, the financing of mental health services will probably involve better utilization of private sector resources. Private insurance dollars will most probably continue to provide for short-term inpatient hospitalization, but the many concerns surrounding the long-term care of the mentally ill have yet to be addressed by insurance providers. The public and private sector will be forced to deal with the transfer of insured people to public sector financing due to limited or inappropriate benefit coverage as there will be very little private initiative for providing dollars for the care of the long-term mentally ill. A national system of compulsory health insurance, preferred provider organizations, long-term care insurance and other potential health insurance trends could produce significant impacts in the future reimbursement of mental health care.

Cost containment pressures will require the development of new criteria for treatment programs, utilization review mechanisms and new treatment programming which will have a profound effect on mental health financing. A shift in treatment focus from inpatient to outpatient care will result in the development of alternatives to inpatient care. Significant reductions in public and private entitlements and benefits will continue to affect long- and short-term care of the mentally ill. Prospective pricing systems for health care will probably be implemented and the development of a competent pricing mechanism for psychiatric care is pressing.

In the face of a "cutback and cost containment" national policy, public mental health programs will be faced with increasing service demand. Shrinking public support will give rise to opportunities for creative and effective management strategies to meet the needs. Human service organizations will need to develop sound strategies for retaining their share of financial resources and to establish effective programs which will maintain and enhance financial viability. Programs providing mental health services will be forced to implement revenue-producing activities to supplement declining support through the intensive marketing of services to the public sector or other entrepreneurial efforts.

CASE STUDY: OREGON

INTRODUCTION

In an attempt to address the need for increased programming for acutely and chronically mentally ill persons, a Governor's Task Force was established in November 1979. Based upon information provided in the 1981 Task Force Report, the legislature directed the Mental Health Division to develop a plan for shifting state hospital funds to community programs through a series of county projects designed to reduce state hospital usage. Additionally, the legislation established the services to be provided in the community and established priority populations to be served.

The Hospital/Community Shift Projects in seven counties were implemented in 1982 and 1983. At the conclusion of the projects, it was found that project counties had maintained a 26 percent reduction in state hospital utilization, that quality of life was significantly improved for those persons participating in the projects and that $2.5 million was transferred from the state hospital to community programs (8). Based on results of the projects, the legislature in 1983 adopted a plan in which all counties would assume responsibility for state hospital utilization and would restructure the state hospitals in an effort to develop a more effective system.

Oregon was not able to avoid reductions in the state mental health system during the economic crisis over the past few years and local mental health funding diminished. As a result of increased utilization, the state was forced to increase funding to the state hospitals. The state is currently facing the decertification of one state psychiatric facility. Although the economy of Oregon currently is beginning to stabilize, the state has not completely recovered from the recession and funding for mental health services is uncertain at a time when demand has increased greatly.

To address specifically Oregon's issues and concerns regarding mental health care funding, the NCSL Mental Health Project agreed to provide the state with a technical assistance program in March 1986. Members of the House of Representatives and Senate, legislative staff and state government personnel provided information on the mental health financing problems in Oregon. Robert Okin, a staff psychiatrist at the Greater Lynn Mental Health Center and Massachusetts General Hospital and a former Commissioner of Mental Health for Massachusetts and Vermont, provided information on shifting resources from the hospital to the community. Howard Goldman, director of Mental Health Policy Studies at the University of Maryland, addressed federal initiatives on mental health financing. James O. Gibson, executive director of Netcare Corporation, provided information on innovative mental health funding strategies. The suggestions presented are not necessarily those of the NCSL Mental Health Project nor the National Institute of Mental Health.

SHIFTING RESOURCES FROM HOSPITALS TO THE COMMUNITY

During the past two years, utilization of Oregon's largest state hospital (one of three) has increased significantly. The division was forced to obtain additional resources for this hospital and in both 1984 and 1986, funding and staffing were increased.

The Mental Health Division is unable to attribute the increased census in the state hospitals to any one cause but has identified a number of possible contributory factors (9):

- Community-related factors including new working relationships between the county and hospital staff, decreased funding which reduced community services and a tendency to bypass the county "gate keeper" program;

- Hospital-related factors such as the need for additional coordination between the hospital and community, increased admissions to the state hospitals and staff vacancies at the state hospital; and

- External factors including increased numbers of mentally ill requiring hospitalization, funding restrictions which forced agencies to be more restrictive and informed consent procedures which increased length of stay.

According to Dr. Robert Okin of the Greater Lynn Community Mental Health Center and the Massachusetts General Hospital, most states have made the mistake of trickling money into the community mental health system at a rate so slow that the decline in state mental hospital census was not sufficient to free up the resources needed in the community. Far from being able to reallocate state hospital resources, states were faced with rising hospital costs at the time the hospital population was declining. A host of financial factors can spur the need for continued institutional resources, including (10):

- Severe inflationary pressures on institutional budgets;

- Shift in the composition of state hospital patients toward a more severe population;

- Surge of right-to-treatment suits;

- Increasingly rigorous standards imposed by accrediting and certifying authorities; and

- Reorientation of the state hospital from a custodial to a rehabilitative facility.

The divided administrative structures and the lack of common government responsibility for the patient in both systems promoted discontinuity of care between the institutional and the community system. Separate budget structures made the smooth transfer of both human and financial resources difficult and the risk of losing future appropriations within either system created a reluctance to transfer excess resources. Additionally, projected resource transfers resulted in institutional union resistance and an attack on deinstitutionalization practices.

The Oregon mental health system could possibly improve the shifting of resources from institutional to community settings by making use of certain strategies which have proved helpful in other states, such as Massachusetts (10).

- Commitment to Community Treatment Established--The Massachusetts mental health system committed itself to the principle that even the most disabled mentally ill people had a right to treatment in the least restrictive, most normalized setting.

- Clinical Assessment Developed--To implement this principle, the state performed a clinical assessment of each person in the state hospitals and determined residential and support services needed to live in the community.

- Resource Plan Developed--After individualized service plans for each patient were developed, the resources needed to implement the plan were determined. An approximate blueprint was developed of services and resources needed to treat all but a small group of dangerous patients in the community.

- Health Forum Established--Next, Massachusetts established a forum consisting of the Association of General Hospitals, the Association of Mental Health and the Department of Public Health. The forum agreed that hospitals in each catchment area that requested a certificate of need for psychiatric beds had to care for voluntary and involuntary patients in the community. This agreement was embodied in the state's health plan and has been enforced through the certificate of need process.

- Administrative Structure Consolidated--The commissioner of Massachusetts then eliminated the position of state superintendent and gave each community mental health system in each catchment area authority over the admissions, treatment and discharge process. This provided tremendous incentives for the development of community programs and reasonable transfers of resources.

- Community System Financed--Through the clinical assessment and planning process, the system was able to predict the cost of implementing the plan and the cost of developing services in the community for the first time. With the assistance of key legislators, professionals and citizens new resources were obtained to expand the community system rapidly and agressively. Instead of an equitable distribution across the state, the resources were allocated to those areas which could develop community alternatives rapidly and responsibly.

Additionally, there are several factors which are key to the successful shifting of resources from state hospitals to community programs (10).

- Legislative mandates directing community mental health providers to serve the seriously and chronically mentally ill are vitally important for encouraging a coherent policy direction and sense of urgency.

- These mandates should require a critical mass of services which are focused on the acutely and chronically mentally ill. Without a comprehensive array of services, the community system would be extremely inefficient in providing alternatives to institutional care.

- The shifting of resources from state hospitals to community mental health services requires significant reductions of institutional admission and census rates and can only be accomplished by fully expanding community services. A reduction in state hospital spending should only come about in the context of a more expensive mental health system than exists today.

- In the past, the need for increased resources has not been declared, resulting in unrealistic expectations. Public debate should occur most vigorously over whether or not the state has a responsibility to provide reasonable and appropriate services to the seriously mentally ill. The discussion of resources should follow from the conclusion of this debate, not precede it.

EXPANDING REVENUES TO MEET INCREASED DEMAND

At the same time that Oregon began facing economic difficulties resulting in significant state funding reductions, the federal government initiated funding cutbacks. Demand for mental health services greatly increased. In Oregon, an estimated 58 percent of the 18,000 who are at risk of hospitalization or require continuing care receive community services. Of Oregon's priority two Population, those with mental or emotional disorders who are unlikely to obtain needed services, only 10 percent of the estimated 65,000 are served. Although many areas of Oregon suffer resource shortages, those areas surrounding state psychiatric facilities experience continual deficiencies due to the critical mass of the psychiatric population (8).

With increasing demands on current services and potential shortfalls in governmental funding, states need to investigate and implement stategies which will expand existing and potential sources of funding. Oregon should consider strategies at all governmental levels and within the public and private sectors which could enable the expansion and development of mental health funding.

Federal, state and local government. Multiple governmental financing mechanisms must be able to allocate finite resources for increased demands and expectations through effective and efficient use of resources.

- Contract with outside agencies for as many direct services as possible, instead of the state providing services directly.
- Create and implement incentives for less restrictive treatment settings since community-based services are generally more cost-effective.
- Encourage interagency collaboration to share resources and minimize replication of services.
- Ensure that persons eligible for disability programs, such as SSI, receive the benefits.
- Determine workable alternatives to diagnosis related groups (DRGs) for mental health treatment cost containment measures.
- Use available federal monies and programs effectively and efficiently. Obtain Community-Based 2176 waivers, establish rate setting provisions for psychiatric sections of nursing homes and pursue available block grant mental health funds.

States can also investigate legislative measures to finance health care which could be applicable for funding mental health services. Such applicable measures could include hospital assessments, proceeds from specific taxes or revenues from gambling or lotteries, establishment of trust funds, all payer-prospective reimbursement systems, income tax check-off and charges attached to health insurance plans and premiums.

Private Sector Financing. As with public financing, there is continual competition among mental health service providers for private sector funds. Although the continual tapping of foundations to fund publically financed programs may jeapordize those privately financed programs which bridge service gaps, states must be aware of potential initiatives which could supplement resources. The Robert Wood Johnson Foundation will be providing $32 million to eight urban mental health systems for the chronically mentally ill in 1986. In addition, the U.S. Department of Housing

and Urban Development will be making loan subsidies for the construction of housing units and rent subsidies for housing the mentally ill. Portland is one of the 60 cities eligible for application to this initiative.

Mental health programs across the country are attempting to create a revenue base that will yield financial stability and capacity. Enterprise in the mental health non-profit sector could include a variety of measures to supplement the financial base of an organization or program (11).

- Lateral Corporation--This effort could house those services not directly paid for by a government entity. For example, if the base organization were a mental health center, the lateral corporation could provide conferences and workshops for the public and employee assistance plans for businesses.

- Non-profit Foundation--A program of this type could carry out resource development activities, such as charitable remainder trusts and annuity trusts, gifted annuities, pooled income funds and creative use of life insurance.

- 501 (c)(2) Holding Company--This company could hold title to and manage real estate for the base non-profit organization. This venture would enable an organization to ensure that revenues collected from government sources would be used for lease rather than for mortgage payments.

- Employee Benefit Corporations--This type of program houses employee benefits in a subsidiary corporation, which allows an employer and employees to contribute to their own reserve fund rather than an insurance company's reserve fund. The reserve can be used in later years to modulate benefit increases and improve benefit plans.

- Creative Venturing--The non-profit organization can pursue revenue-generating possibilities that are beyond its normal mission, such as acquiring and leveraging properties and joining investors in co-ventures.

- For-profit Subsidiary--A program of this type can engage in profit-making business activities. By establishing a for-profit entity, a nonprofit organization will not run the risk of losing tax exempt status by surpassing the allowable income level from an unrelated activity.

Private insurance companies are realizing that while mental health benefits are costly, they are not as costly as trying to avoid meeting real needs. Insurance payment systems need to be developed which meet the needs of the mentally ill rather than focusing on payment rates for a treatment setting or specific unit of service. Possible action includes:

- Legislating reasonable mandatory coverage for mental illness which does not limit what coverage is already available;

- Developing alternatives to institutional care, including residential and outpatient care in lieu of more costly hospitalization;

- Meshing public and private care through the use of public and private vouchers to fill the coverage gaps of private insurance plans; and

- Developing coverage for chronic or long-term patients, including catastrophic mental health coverage, risk pool insurance, long-term care, medical retirement accounts and national health coverage.

CONCLUSION

During this era of cost containment, declining resources and increased service demand, Oregon and other states will be challenged to develop more efficient systems. States will be forced to weigh the issues of quality, cost-containment and choice in determining the future structure and composition of mental health care. Oregon and other states must remember that if mental health funding is jeopardized, especially for the chronically and severely ill populations, society will pay an even greater price.

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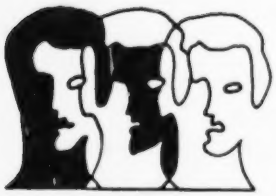

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

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